NORTH SHORE DENTISTRY

2101 E. CALUMET ST.
APPLETON, WI 54915

(920) 731-1550

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have reviewed a copy of this office's Notice of Privacy Practices and the state of Wisconsin Addendum. By signing this form, I am confirming my written permission for the disclosure of my protected health information (PHI).

PRINT YOUR NAME (FIRST, LAST, MIDDLE INITIAL)

SIGNATURE DATE

ADDRESS PHONE NUMBER

PLEASE READ THE FOLLOWING INFORMATION

You have the right to read our privacy practices notice before you decide to sign this consent. Our notice provides a description of the uses and disclosures we may make of your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully before signing.

This consent is a condition of your treatment by us. If you decide not to sign this form, we may decline treatment to you. (Persons 18 and older must sign their own form.)

You have the right to revoke this form at any time, by giving written notice to the contact person listed in our notice.

PLEASE LIST ANY **DEPENDENTS** (UNDER THE AGE OF 17 ONLY) BELOW.
PLEASE LIST ANY **FAMILY MEMBER OR PERSONAL REPRESENTATIVE** IN ORDER TO ASSIST WITH YOUR HEALTHCARE NEEDS/FINANCIAL OBLIGATIONS BELOW.

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ INDIVIDUAL REFUSED TO SIGN
- ☐ COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT
- ☐ AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT